Please complete the following so that we may contact you properly and securely.

- Please list the family members or other persons, if any, whom we may inform about your child's general medical condition and diagnosis (including treatment, payment and health care operations).

Name _____

Phone _____

Name _____

Phone _____

- Please list the family members or significant others, if any, whom we may inform about your child's medical condition ONLY IN AN EMERGENCY.

Name _____

Phone _____

Name _____

Phone _____

- Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

_____

_____

- Please print the telephone number(s where you want to receive calls about your appointments, lab and X-Ray results, or other health care information if other than your home telephone number.

_____

_____

_____

Please be aware that a cell phone is not a secure and private line.

Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL." ☐ YES ☐ NO

Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail? ☐ YES ☐ NO

_____

PATIENT NAME *print* (Parent/Guardian, if under 18 years)

_____ Date _____

PATIENT SIGNATURE (Parent/Guardian if under 18 years)

Notes:

_____

_____

_____

_____